Statement of Bruce C. Vladeck
Administrator, Health Care Financing Administration

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Overview: President's FY1998 Budget Proposal

The President's Budget Proposal for 1998 reflects the continuing commitment of this Administration to assure high quality health care for Medicare and Medicaid beneficiaries while working toward providing health care coverage for all Americans. The President's Medicaid proposal guarantees coverage for Medicaid beneficiaries; addresses the needs of States for greater flexibility; and responsibly controls expenditures while investing wisely in expanded coverage, especially for children.

While reforming and streamlining Medicaid, the President's overall plan saves a net $9 billion over the next 5 years. Savings would be achieved through a combination of policies that limit Federal spending on a per person basis and reduce and retarget Disproportionate Share Hospital (DSH) payments to facilities that serve large numbers of Medicaid and uninsured patients. The savings equal $22 billion over 5 years. The President's Budget also invests $13 billion for several Medicaid initiatives. These address the health care needs of individuals adversely affected by the new Temporary Assistance for Needy Families legislation as well as health care needs of children. Through Medicaid and other programs, our new Children's Initiative would help to provide health insurance to as many as 5 million children who would otherwise be uninsured or who are not now enrolled in Medicaid.

In addition, the President's plan provides States with much greater flexibility to develop innovative and more efficient health care delivery and payment systems. These proposals would provide new opportunities for States to generate administrative and program savings and expand health care coverage.

The Medicare provisions in the President's Budget are part of an aggressive strategy to strengthen Medicare and modernize it for the 21st century. Our goal is to become a more prudent purchaser of high quality health care that meets the needs of all of our beneficiaries, especially the most vulnerable. Almost 75 percent of Medicare beneficiaries have incomes below $25,000, and while the average American household spends 8 percent of its income on health care, elderly Americans spend nearly 21 percent of their income on health care services. The President's proposal strengthens Medicare through structural reforms, operational modernization, greater market responsiveness, and improved benefits.

THE MEDICAID PROGRAM

1998 Budget Savings

During FY 1996, Federal Medicaid expenditures were $92 billion and helped pay for services to nearly 37 million Medicaid beneficiaries. In the President's 1998 Budget Proposal we achieve net savings of approximately $9 billion over 5 years, which would be used to reduce the budget deficit. Through a combination of a per capita cap and DSH reductions, we achieve gross savings of $22 billion over 5 years. The plan also invests $13 billion in improvements to Medicaid. Because recent Medicaid expenditures as well as those projected over the next 5 years have grown more slowly than expected, the $9 billion net savings proposed in this budget is considerably lower than what was proposed during the last Congress.

Last year, Medicaid spending growth was historically low. The 1996 growth in overall Medicaid expenditures was less than 4 percent. The Administration now projects that Medicaid spending over the next 5 years will be at least $68 billion less than projected a year ago in the President's 1997 budget.

A main reason for this notable decline in the Medicaid growth rate is legislative changes enacted in 1991 and 1993 limiting spending on Disproportionate Share Hospitals (DSH) and putting restrictions on Federal matching on provider donations and taxes. These bipartisan solutions to the problem of overuse of both DSH and provider donations and taxes in the late 1980s has contributed to slowing the total expenditures growth from its all-time high of 31.7 percent in FY1991 to an average growth of 7.2 percent projected between 1997 and 2002. States have also contributed to lower growth rates by using their new flexibility to contain costs. Other reasons for slower growth include lower projections of inflation and Medicaid enrollment.

Despite the reductions in the baseline, we expect Medicaid growth rates to begin to increase more rapidly again, beginning in 1998. Under the Administration's new baseline projections, the per capita Medicaid growth rate would be about 5.5 percent from FY1997 to FY2002, climbing to 5.9 percent in FY2000. CBO estimates that between 1997 and 2002 the average growth rate in per capita Medicaid spending will be approximately 6.3 percent, and annual growth is projected to be greater than 6.5 percent a year after FY2000. We firmly believe that, as part of a balanced budget strategy, we must have a way to protect against future growth in Medicaid expenditures.

Per Capita Cap

The per capita cap establishes new accountability in spending growth per Medicaid beneficiary, guarantees Federal matching funds for eligible individuals for a guaranteed set of

benefits, and protects States and beneficiaries during periods of economic recession and other changes that may increase Medicaid enrollment.

We believe that the per capita cap as described below is the best way to achieve budgetary discipline in the Medicaid program. The per capita cap is designed to maximize States' responsiveness to the health care needs of their Medicaid populations while adapting to changing economic circumstances.

The per capita cap is calculated based on an estimate of what spending would be if spending growth per beneficiary were limited to a specified index. The cap applicable to a given State in a given year would be an aggregate of the individual caps for four groups of beneficiaries in the State: aged, disabled, adults in families with children, and children. The cap for each group would be the product of:

- total State and Federal spending in the base year (1996), including administrative costs, per beneficiary in the group;
- the number of beneficiaries in the group for the current year;
- an index specified in legislation; and
- the Federal matching rate.

Certain aspects of Medicaid spending not tied to individual beneficiaries or not under direct control of the States would not be subject to the cap: vaccines for children, payments to Indian health providers and the Indian Health Service, Disproportionate Share Hospital (DSH) payments, and Medicare premiums and cost sharing for dual eligibles and qualified Medicare beneficiaries (QMBs). On the other hand, Medicaid expenditures for administration services delivered under Section 1115 demonstration waivers would be subject to the per capita cap.

The spending for each of the four groups would be combined to establish the spending limit for the State. Each State would be able to use savings from one group to support expenditures for other groups or to expand benefits or coverage. The Federal match would continue as under current law until the total capped amount for the State is reached.

The index we have used is the growth in nominal GDP per capita (based on a 5-year rolling historical average), plus adjustment factors that account for Medicaid's high utilization and intensity. Over the budget period, the index would allow per capita spending to increase by an average of 5 percent per year. By FY1999 and subsequent years, the index would equal nominal GDP plus 1 percentage point. Our policy development to this point has focused on an index based on nominal GDP. There is a debate about which is the most appropriate index. Last year, some members of Congress suggested using the CPI, and we are reviewing an index that could more precisely reflect growth in health care costs and, in particular, the volume and intensity inherent in a program that serves many low-income people. When our work is complete, we will share that information with the Congress, the States, and other stakeholders, in order to facilitate the development of the best index possible.

What this means is that, after FY2000, when both the HCFA Actuaries and CBO's analysts have indicated that they expect Medicaid spending growth on a per capita basis to rise more rapidly again, the per capita cap would constrain Medicaid growth per person (for non-DSH benefits and administration) to about 5 percent per year. If we and the States are successful in holding the spending growth per beneficiary to about 5 percent per year during this period - which is close to the annual growth rate CBO is projecting for private insurance on a per person basis - the per capita cap will produce little to no savings. But if the analysts are correct, and per capita spending growth rises again, our policy will prevent that increase from overtaking our balanced budget.

It is clear that we would need the best possible data to implement a per capita cap appropriately for each State. We would need to make some modifications to the existing data reporting systems. For example, we would need all States to participate in the Medicaid Statistical Information System (MSIS) program in which twenty-nine States now participate. MSIS permits collection and analysis of person-based data on eligibles, recipients, utilization and payment for Medicaid services. This data is already extremely useful for State program management and federal analysis and monitoring under current law and would be vital to successful implementation of the per capita cap.

Disproportionate Share Hospitals

As the next chart shows, Medicaid spending for disproportionate share hospitals increased from well below $1 billion in 1988 to $10 billion by 1992. [MEDICAID CHART #1] Laws enacted in 1991 and 1993 have slowed this growth; however, today's Disproportionate Share Hospitals (DSH) program is still too large.

A recent study by the Urban Institute of the Medicaid Disproportionate Share and Other Special Financing Programs in 39 States demonstrates that a significant amount of Medicaid DSH dollars are being spent without demonstrable benefit to Medicaid recipients or reductions in uncompensated care. The Urban Institute found that even after the implementation of the Disproportionate Share Hospitals program changes enacted in 1991 and 1993, "approximately one-third of total DSH expenditures leave the health care system." The Urban Institute study asserted that these funds that "leave the health system" are used by States for other, non-health related purposes.

We propose to achieve two-thirds of our total Medicaid savings through reductions in the Disproportionate Share Hospitals program. The Administration's policy essentially freezes DSH spending in FY1998 at FY1995 levels, with a gradual decline to $8 billion in spending for FY2000 to FY2002. DSH savings are achieved by taking an equal percentage reduction off of States' FY1995 DSH spending, up to an "upper limit." If a State's DSH spending in FY1995 is greater than 12 percent of spending on Medicaid benefits and DSH in that State, the percentage reduction is applied to this 12 percent rather than the full DSH spending amount. This "upper limit" maintains the policy balance struck by Congress in the DSH provisions it enacted in 1991 and

1993, which recognized that some States' Medicaid programs are particularly dependent on DSH spending. Like those earlier Congressional actions, this "upper limit" policy would ensure that the few States with high DSH spending are not bearing most of the impact of the savings policy.

The Administration continues to believe that DSH dollars should be targeted to the providers that need them most: those hospitals and other providers that disproportionately serve a high volume of Medicaid patients, the uninsured, and low-income people. We continue to support better targeting of DSH funds. But because implementing a policy to target DSH funds more effectively is a technically complex issue that could have potentially disruptive effects in some States, our policy does not yet prescribe a mechanism for targeting. We want to work with the Congress, the States, providers, and advocates to develop an appropriate targeting mechanism.

To respond to the special needs of critical safety net providers, the President's plan includes a temporary fund of about $1.4 billion over 5 years to help cover the costs of care delivered in Federally-Qualified Health Centers and Rural Health Clinics. We believe this supplemental fund is necessary to help these providers during their transition to a per capita cap, particularly in view of our proposal to end, effective in FY 1999, the requirement that States reimburse them on a cost basis.

State Flexibility

Under current law, States have considerable flexibility in managing their Medicaid programs. A reflection of this flexibility is the fact that only 45 percent of program funding goes toward mandatory services for mandatory eligibles. The other 55 percent is spent by the States for services to individuals that they have chosen to include in their programs. We plan to further enhance State flexibility while protecting beneficiaries and maintaining fiscal accountability. [MEDICAID CHART #2]

The President's Budget eliminates some current law restrictions on States' ability to set provider payments. The Budget would repeal the long-criticized Boren Amendment, which limits the way States can set their provider reimbursement rates for hospitals and nursing homes. States would be able to use a simplified public notice process for setting hospital and nursing home payment rates. The Budget would also phase out in 1999 the requirement for cost-based reimbursement for FQHCs and Rural Health Clinics; however, we will create transitional funds for these facilities.

The President also proposes increased flexibility for Medicaid managed care programs. Various provisions would eliminate the need for a waiver for mandatory managed care; replace the 75/25 enrollment composition rule with enhanced quality monitoring systems; permit nominal copayments for HMO enrollees; and require an actuarial review of the upper payment limit and the soundness of capitation rates so that they will reflect historical managed care costs.

The President's Budget also allows States to serve people needing long term care in home and community-based settings without Federal waivers.

Another provision would increase States' flexibility to cover people with incomes up to 150 percent of the Federal poverty level. This proposal lets States cover new groups and employ simplified eligibility rules in a budget neutral manner without applying for a Federal waiver.

The President's Budget Proposal would also eliminate a number of unnecessary administrative requirements. We would replace the physician qualification requirements for obstetrical and pediatric services with State certification of those providers. We would eliminate what we have found to be unnecessary annual State reporting requirements regarding beneficiary access to obstetricians and pediatricians as well as the requirement that States pay for private health insurance premiums for Medicaid beneficiaries where cost-effective. States would be able to use general performance parameters for electronic claims processing and information retrieval systems instead of detailed Federal standards for computer systems design.

The budget balances these changes with a significantly improved quality assurance process focusing on internal and external quality assurance mechanisms, clear and understandable grievance processes, and ample public notice requirements.

Investments

Child Health **-** There are about 10 million uninsured children in America today, a problem this Administration intends to address. Uninsured children tend to fall into three categories: 1) those whose employer-sponsored coverage is intermittent due to fluctuations in their parent's work status; 2) so-called "gap" children whose family income is too high for Medicaid eligibility but not enough to afford private insurance; and 3) those who are eligible for Medicaid but not enrolled. The goal of the President's child health proposals is to begin to address the insurance and access needs of these children. We have developed a multi-dimensional approach to addressing this complex problem. The next chart shows the number of children we expect to cover using both Medicaid and private sector insurance initiatives. [MEDICAID CHART #3]

We propose two approaches to expand private insurance coverage for children. First, we will fund $750 million per year in partnership grants to States to support programs to cover children who are not now covered by Medicaid or health insurance. This new program is expected to reach about 1 million currently uninsured children through a variety of approaches that States have broad flexibility to design. An important component of this proposal is the spillover effect on Medicaid enrollment -- we estimate outreach conducted as part of this program will find as many as 400,000 children, who are eligible for Medicaid. Second, the President's initiative for workers between jobs would provide up to 6 months of premium assistance to workers, an initiative expected to cover 3.3 million Americans in 1998, including 700,000 children.

We also propose two Medicaid initiatives. First, we would guarantee at least 12 months of continuous eligibility for children ages one and older once they have become eligible for Medicaid. Many children currently have less than a year of Medicaid coverage each year. This proposal is especially beneficial to children with family incomes near the Medicaid eligibility income limit. If States choose this program, about one million children, who otherwise would have been covered intermittently, would have continuous coverage for a full year. Second, we would reach out to the estimated 3 million poor children who are currently eligible for Medicaid, but are not enrolled. We would work actively with the states to identify and enroll them.

In addition, under the bi-partisan expansion of coverage for children passed in 1980, we expect States will enroll an additional 250,000 low-income children in each of the next 4 years.

Welfare Reform Adjustments

The recently enacted welfare legislation particularly affected children and immigrants. Because of the historically close links between eligibility for cash assistance and eligibility for medical assistance, a wide range of Medicaid issues needs to be addressed as a result of the new legislation.

The welfare legislation severed the link between the receipt of cash assistance and automatic eligibility for Medicaid, but maintained the current Medicaid rules. States are required to use the AFDC income and asset rules in place on July 16, 1996 to determine the Medicaid eligibility of AFDC-related groups. However, several issues remain with respect to Medicaid, including assuring that: eligible individuals continue to be enrolled; eligible children with disabilities do not lose Medicaid due to the changed SSI childhood disability definition; and medical assistance continues to be available for eligible legal immigrants.

The President's 1998 Budget Proposal would invest in significant adjustments to the new welfare rules to guarantee medical care for certain immigrants who lose health coverage as a result of welfare reform. States would again be able to provide Medicaid coverage for legal immigrants who qualify as SSI recipients who become disabled after entry into the United States. Disabled immigrants and children would not be subject to the ban on Medicaid coverage nor would their sponsor's income and assets have to be considered in determining their eligibility for Medicaid. Refugees and asylees, facing persecution in their own country, would receive additional protection from the Medicaid bans and sponsor deeming rules.

We would invest additional dollars to retain Medicaid coverage for disabled children currently receiving Medicaid, who lose SSI cash benefits as a result of the new childhood disability definition in the welfare reform legislation.

Last year's welfare reform legislation provided for $500 million to help with the additional administrative burden imposed on States by the need to maintain and operate two separate

eligibility processes. The law charged the Secretary with developing a plan for equitable distribution of this money, and we have worked with intergovernmental groups representing the Governors, Legislatures, and State welfare and Medicaid agencies in determining the method and factors to be used in allocating this money. We will soon publish a Federal Register notice proposing an allocation formula for distribution of the $500 million to the States.

Provision to Help Workers with Disabilities

The budget proposes to help people with disabilities work without losing their health care coverage. Today, people on Supplemental Security Income (SSI) who go to work lose Medicaid if their earnings exceed caps that vary by State. Yet, it is often especially difficult for people with disabilities to get private insurance, especially coverage for any preexisting conditions. As a result, many people who are eligible for SSI "manage" their income to ensure that they keep Medicaid -- by stopping work when they hit the caps, or even turning down promotions. The President's proposal would create a new State option that would allow SSI beneficiaries with disabilities who earn more than these caps to keep Medicaid by contributing to the cost of their coverage as their income rises.

THE MEDICARE PROGRAM

I am pleased as well to present the Administration's plan for modernizing Medicare. I am enthusiastic about the initiatives we have undertaken to ensure that Medicare is strengthened for the 38 million Americans who depend upon it, offers the best possible medical care, and enters the next century in robust condition.

We think it is important to put a human face on the equation and to be fully aware of the serious impact such proposals would have on Americans least able to bear these additional cost burdens. Although only 10 to 12 percent of Medicare beneficiaries fall below the Federal poverty line, nearly 75 percent have incomes below $25,000. [MEDICARE CHART #1] Medicare is often described as a middle-class benefit, but beneficiaries are middle class precisely because they have Medicare. Recent data indicates that the elderly already spend a formidable 21 percent of their income on health care, compared to 8 percent spent by the non-elderly.[MEDICARE CHART #2]

The Medicare provisions in the President's FY 1998 Budget have two primary goals: (1) to extend the life of the Medicare Trust Fund into the next decade which will contribute to reduction of the deficit; and (2) to modernize Medicare. Through sound judgment and careful planning, we can guarantee that the Medicare program of the future will continue to provide the same protections to the elderly and disabled as it does today.

EXTENSION OF MEDICARE SOLVENCY INTO 2007

Under present law, the Hospital Insurance Trust Fund would be depleted early in 2001, based on the Board of Trustees' intermediate estimates. The President's budget proposals would extend the life of the Trust Fund by another 6 years, and would provide adequate financing services throughout the next 10 years. This extension would leave us time to tackle imminent fiscal problems precipitated by retiring baby boomers. Savings would be achieved through a combination of savings from reductions in payments to hospitals, home health agencies, skilled nursing facilities, managed care plans, and other providers. As was proposed in the previous two balanced budget initiatives, it would permanently extend the 27 percent Part B premium.

Moderating Medicare's Rate of Growth

The President's budget includes explicit proposals to achieve $100 billion in savings over the next 5 years. Medicare per capita spending growth over the next 5 years (1997-2002) would slow from the current projected rate of 7.4 percent to 5.3 percent. In 2002, this would lower our average per capita spending from $7,800 to $7,100. [MEDICARE CHART # 3] These savings come from substantial reductions in payments to providers. The largest share of the Medicare savings would come from Part A providers.

Managed care - Through a series of policy changes, the plan would address the flaws in Medicare's current payment methodology for managed care. Specifically the reforms would create a national floor to better assure that managed care products can be offered in low payment areas, which are predominantly rural communities. In addition, the proposal includes a blended payment methodology, which combined with the national minimum floor, would dramatically reduce geographical variations in current payment rates. The plan would reduce reimbursement to managed care plans by approximately $34 billion over 5 years. Savings will come from three sources: (1) Because HMO payments are updated based on projections of national Medicare per capita growth, when the traditional fee-for-service side of the program is reduced, HMO payments are reduced; (2) The carve-out of the medical education and DSH payments from the HMO reimbursement formula (these funds will be paid directly to academic health centers); and (3) A phased-in reduction in HMO payment rates from the current 95% of fee-for-service payments to 90%. A number of recent studies have validated earlier evidence that Medicare significantly overcompensated HMOs. A recent HCFA study has validated earlier findings by Mathematica Policy Research that Medicare overpays HMOs. The reduction does not start until 2000 and it accounts for a relatively modest $6 billion in savings over 5 year.

Physicians - We propose to establish a single conversion factor for payments under the physician fee schedule and to reform the method for updating physician fees. By creating incentives to control physician services in high-volume inpatient settings and to make a single payment for surgery where an assistant-at-surgery is used, costs would be reduced. We also propose to expand the settings in which direct payment is made to physician assistants, nurse practitioners and clinical nurse specialists to include home and ambulatory settings. Medicare currently does

not have an expansive outpatient drug benefit, though there is coverage of certain kinds of outpatient drugs. Our proposed plan would eliminate the mark-up charged by physicians and suppliers, limiting payments to acquisition costs subject to a limit. In addition to eliminating the current statutory x-ray requirement to determine the need for a service, we also propose to improve access to chiropractic services. These proposals would result in savings of $7 billion over 5 years.

Fraud and Abuse

The President's budget contains a number of proposals to reduce waste, fraud and abuse in the Medicare program. Among these proposals are provisions to require insurance companies to report the insurance status of beneficiaries to ensure that Medicare pays appropriately. In addition, we have several proposals to prevent excessive and inappropriate billing for home health services. We are proposing to close a loophole in the current payment calculation by linking payments to the location where care is actually provided, rather than the billing location. When we implement the PPS, we will eliminate HHA periodic interim payments (PIPs), which were originally established to encourage HHAs to join Medicare by providing a smooth cash flow. Since over 100 new agencies join Medicare each month, inducements are no longer needed. We will develop more objective criteria for determining the appropriate number of visits per specific condition, so that we can prevent excessive utilization.

Finally, the President's budget calls for the repeal of several provisions in the HIPAA that could hamper our ability to fight fraud and abuse. First, the President is proposing to eliminate the broad new exception to the anti-kickback statute when providers are at "substantial financial risk." These terms are undefined and somewhat broad. Additionally, the Congressional Budget Office assigned a cost to this provision because it could be easily abused by those wishing to profit from referrals. Second, the President is proposing to eliminate the requirement that advisory opinions be issued in response to specific requests as to how certain business arrangements may or may not be considered to violate the anti-kickback laws. This provision will hamper the government's ability to prosecute fraud, and is impractical because it is difficult, if not impossible, to determine intent based on the submission of the requestor. Third, the President is proposing to reinstate the "reasonable diligence" standard. HIPAA eliminated the current standard for use of reasonable diligence and made providers subject to civil monetary penalties only if they act with deliberate ignorance or reckless disregard.

Modernizing Medicare

The President's Budget modernizes Medicare and brings it into the 21st century through major structural changes in seven areas: Prudent Purchasing; Modernizing Managed Care Choices; Preventive Care; Beneficiary Protections; Program Improvements; Integrated Quality Management; and Improving Access in Rural Areas (which I will not cover here because it falls

under Medicare Part A). [MEDICARE CHART #4]

1 - Prudent Purchasing

As more beneficiaries are choosing to enroll in managed care, there has been a lot of talk about fee-for-service being the "residual," as though it were somehow not important. We must recognize that even if we double the rate at which beneficiaries are moving into managed care in the short-term, the majority of beneficiaries would still be in fee-for-service. We therefore need to look for ways to improve our purchasing power. Over the past several years, private sector purchasers of health services have developed a variety of innovative ways they pay for health services. It is ironic that HCFA, the largest purchaser of health services in the U.S., has often been shackled by outdated statutory payment and administrative pricing provisions, which prevent us from adapting to today's marketplace.

Beneficiary-Centered Services - Given the pressures on the federal budget, it is critical that Medicare look beyond traditional purchasing strategies and scan the private industry horizon for new ideas. HCFA's "Beneficiary-Centered Purchasing Initiative" proposals do just that, applying lessons learned from the private sector and our demonstrations. With these proposals, we would have innovative purchasing arrangements which would be powerful tools to control Medicare spending now and in the future.

For example, under our "Centers of Excellence" demonstration, Medicare achieved an average of 12 percent savings for coronary artery bypass graft procedures performed, with no reduction in quality. Despite this success, we do not have the authority to make the Centers of Excellence program a permanent part of Medicare. Similarly, while other purchasers of health care services are successfully using disease and case management services to selectively provide services for enrollees with specific conditions (e.g. diabetes, congestive heart failure), we do not have this kind of authority under Medicare fee-for-service. The Office of the Inspector General reports indicate that Medicare is paying far more for medical supplies and DME than other federal purchasers such as the Department of Veterans Affairs. Nevertheless, Medicare lacks authority to use competitive bidding to establish payment rates. I urge Congress to re-examine these issues and give the Medicare program the flexibility to pay on the basis of special arrangements, as opposed to statutorily-determined, administered prices.

Post-acute Services - Home health care plays a significant role in the ability of many elderly to continue to live at home: 1 in 3 home health users live alone, and 4 in 10 have incomes below $10,000. Under the Administration's proposal, the first 100 visits following a 3-day hospital stay would be reimbursed under Part A, just as this program covers 100 days of skilled nursing care following a hospitalization. All other home health care (visits beyond 100 and those not following a hospital stay) would be paid under Part B. Prior to OBRA '80, the Part A portion of the home health benefit was limited in this way. OBRA '80 legislation eliminated the 3-day hospitalization requirement and the visit limits and, in so doing, made Part A responsible for almost all of the financing of home health. The restoration of non-post acute visits to Part B

makes the home health benefit consistent with the original intent of the Medicare statute and its division of services between Part A and Part B. In addition, the Administration is proposing to reallocate some of the home health financing to Part B to restore the post-acute care nature of Part A.

Contract Reform - While modernizing our payment methods for purchasing health care services for beneficiaries is an essential step toward modernization, we must modernize the way we purchase administrative services. The President's budget contains a proposal that would end the requirement that all Medicare contractors (that is, carriers and intermediaries) perform all Medicare administrative activities. It gives HCFA the tools to take advantage of innovations and efficiencies in the private sector when it comes to utilization review, beneficiary and provider services, and claims processing. It builds upon the authority granted in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, where payment integrity activities (such as audits) could be separately contracted. This provision would also allow us to use the same competitive requirements that apply throughout the government when awarding new contracts, to expand our pool of potential contractors beyond insurance companies to other entities that may be well qualified to do the work.

2 - Modernizing Managed Care Choices

Under our Medicare Choices initiative, we would expand managed care options, provide beneficiaries with comparative information on all of their health care choices, ease comparison among options by increasing standardization of benefits, provide a coordinated open enrollment period and other open enrollment opportunities and institute Medigap reforms. Let me address each of these components separately.

Expanded Managed Care Options - Currently, HCFA can contract with Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) to serve as Medicare managed care plans. The Administration believes that Medicare beneficiaries should have more managed care choices, comparable to those available in the private sector. Thus, the President's budget would expand managed care options to include Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs). We believe that direct contracts with alternative managed care models such as PSOs are the key to expanding managed care to rural areas.

Comparative Information - Under current law, beneficiaries may obtain comparative information on Medigap options through State Insurance Counseling Grant Programs. Some of these programs also address managed care options. There are no mechanisms, however, to ensure that beneficiaries are aware of all their options, in both managed care and Medigap. Under the President's budget, the Secretary would develop and provide comparative information to beneficiaries on all managed care plans and Medigap plans in the area. This information would be used by State Insurance Counseling Grant Programs to assist beneficiaries in understanding their

coverage options. The costs of preparing and disseminating this information and supporting the

State Counseling Grant Program would be financed by the Medigap and managed care plans.

Standardized Benefits - While comparative information would be helpful to beneficiaries, making an informed decision among the array of available coverage options would be hampered unless differences in benefit packages are addressed. Under the President's budget, the Secretary would establish standardized packages for certain additional benefits offered by managed care plans. For example, if the Secretary established a standardized package for outpatient prescription drugs, plans could offer enrollees this benefit only according to the structure established by the Secretary. The development of standardized additional benefit packages would make it possible for beneficiaries to compare these benefits on the basis of cost and quality. The National Association of Insurance Commissioners (NAIC) would also review the current standard Medigap packages to see if changes could be made to ease comparison with the standard managed care benefits.

Open Enrollment Opportunities - Under Federal law, aged individuals have a once in a life-time opportunity to select the Medigap plan of their choice when they first join Medicare at age 65; individuals who become eligible for Medicare because of a disability or end-stage renal disease beneficiaries have no such choice. If a beneficiary enrolls in a managed care plan and is later dissatisfied, he or she may not have the opportunity to select the Medigap plan of his or her choice; for example, drug coverage may be unavailable due to the individual’s poor health status. As a result, some beneficiaries are reluctant to try managed care or are fearful of being locked into managed care options with no opportunity to return to fee-for-service and Medigap.

The President's Budget gives all new beneficiaries, not just aged beneficiaries, the opportunity to choose the managed care or Medigap plan of their choice when they first enroll in Medicare. In addition, each year all Medigap and managed care plans would have to be open for a 1-month coordinated open enrollment period. Additional open enrollment opportunities would be available under certain circumstances -- such as, when a beneficiary's primary care physician leaves a plan or when a beneficiary moves into a new area. While the concept of coordinated open enrollment is not new and was included in the Budget Bill in 1995, the key difference in our proposal is the inclusion of Medigap plans.

Other Medigap Reforms - In addition to addressing open enrollment, there are other Medigap reforms included in the President's budget. We would like to eliminate the ability of Medigap insurers to impose pre-existing condition exclusion periods. Under the policy in the President's budget, a Medigap plan cannot impose an exclusion period for a beneficiary who has recently enrolled in another Medigap plan, Medicare managed care, or employer-based plan. This is similar to the policy included in a bill introduced by Mrs. Johnson during the last session and we look forward to working together toward enactment this year.

Our final Medigap reform addresses rating. There are currently no federal requirements regarding the rating methodology used by Medigap plans. As a result, plans can use low premiums to entice beneficiaries to enroll in their fledgling stages, but as the company matures it

raises the premiums to unaffordable levels. Under the President's budget, Medigap plans would be required to use community rating to establish premiums. The movement to community rating would be subject to a timetable and transition rules developed by the NAIC. Given that managed care plans are required to charge all enrollees the same premium, Medigap plans should not be allowed to charge differential premiums based on age. Also, if choice is an important goal, then premium structures, such as attained age rating, which in effect make Medigap unaffordable as beneficiaries age should not be allowed.

3 - Preventive Care

One of the core elements of our restructuring agenda is modernization of Medicare's coverage of preventive care. The cost-effectiveness of illness prevention is well-known; in the long run, preventive medicine pays for itself. The President's budget would make some significant improvements in the area of preventive benefits. I would note that there is a bipartisan consensus on many of these proposals as indicated by the similarities between our initiatives and legislation sponsored by Chairman Thomas, Mr. Cardin and Mr. Bilirakis. We look forward to working with you on these proposals:

Colorectal Screening Coverage - Colorectal cancer is the second most common form of cancer in the U.S. and has the second highest mortality rate. Yet, despite the demonstrated importance of early detection, Medicare does not pay for procedures used to detect colorectal cancer when used as a screening tool. The President's budget would provide such coverage, thereby increasing the possibility of early detection and treatment of colorectal cancer.

Mammography Coverage - The early detection and treatment of breast cancer is a high priority for HCFA. Forty-eight percent of new breast cancer cases and 56 percent of breast cancer deaths occur in women age 65 and over. Although Medicare covers both screening and diagnostic mammography, only 40 percent of all eligible beneficiaries over age 64 (excluding those in managed care) received a mammogram in the 2-year period from 1994 through 1995. In addition, only 14 percent of eligible beneficiaries without supplemental insurance received mammograms during the first 2 years of the screening mammography benefit, which began in 1991.

The President's budget expands coverage for screening mammograms to provide for an annual mammogram for women age 65 and over. This is consistent with the recommendations of

most major breast cancer authorities. The budget also proposes to waive cost-sharing for mammogram services in order to encourage their use.

Expanded Benefits for Diabetes Outpatient Self-Management Training and Blood Glucose Monitoring - The third area where we propose to make investments is in services for beneficiaries with diabetes. Under current law, Medicare covers diabetes outpatient self-management training only in hospital-based programs, and covers blood glucose monitoring (including testing strips) only for insulin-dependent diabetics. The President's budget would expand coverage of diabetes

outpatient self-management training to non-hospital-based programs, and expand coverage of blood glucose monitoring (including testing strips) to all diabetics.

Preventive Immunizations - Current law provides payment for the administration of pneumonia, influenza, and hepatitis B vaccines, and already waives payment of coinsurance and the Part B deductible for pneumonia and influenza vaccines. The President's budget increases payment amounts for the administration of all three types of vaccines, and waives payment of coinsurance and applicability of the Part B deductible for the hepatitis B vaccine. These measures would improve access to adult vaccinations and make the cost-sharing waiver consistent for all types of covered vaccines.

4 - Beneficiary Protections: Coinsurance Reform and Enrollment Improvements

Reform Beneficiary Coinsurance for Hospital Outpatient Department Services - Coinsurance for Part B services is generally based on Medicare's payment amount. However, for certain outpatient department services (OPDs), coinsurance is a function of hospital charges, which are significantly higher. In addition, as a result of a flaw ("formula-driven overpayment") in the statutory formula determining Medicare's payment for certain OPD services, hospitals have had an incentive to increase their charges. The net effect of charge-based coinsurance and hospitals' increases in their charges is that in 1998, without a change in law, beneficiaries will pay an effective coinsurance rate of 46 percent for OPD services rather than the 20 percent for other Part B services. This effective coinsurance rate is expected to increase to 52 percent by 2007.

The President's budget proposes the establishment of a prospective payment system (PPS) for OPD services in 1999. Total payments to hospitals for OPD services would be established so as to equal total payments that would otherwise apply, minus the effect of the formula driven overpayment. This also assumes the extension of certain OPD policies included in OBRA 93 that are slated to expire in 1999. Coinsurance would be reduced starting in 1999 using the savings from the formula-driven overpayment. It would also be gradually reduced in subsequent years until it equals 20 percent in 2007.

Part B Enrollment and Premium Surcharge - Under current law, with certain exceptions, beneficiaries who do not enroll in Part B when they are first eligible can enroll subsequently only during an annual open enrollment period from January to March of each year, with coverage effective in July. In addition, for each year that they could have enrolled in Part B but did not, they face a 10 percent premium surcharge. While for most beneficiaries the surcharge is in the 20 to 30 percent range, some beneficiaries face a surcharge of 150 percent or more -- an amount which is punitive rather than bearing any relationship to the cost to Medicare of late enrollment.

In recent years, flaws in this enrollment process and inequities in the premium surcharge have become obvious. Beneficiaries who never enrolled in Part B due to availability of other coverage have attempted to enroll after their circumstances changed. For example, beneficiaries may have not have enrolled in Part B because they had generous retiree coverage through their former employers. Years

later, however, they were informed that the former employer was now requiring Part B enrollment or was dropping coverage entirely. There are also situations where military retirees did not enroll in Part B because they could obtain physicians' services through a clinic at the military base near their home. Then, years later, the closing of their base necessitated Part B coverage.

The President's budget would replaces the annual general enrollment period for Part B with a continuous open enrollment period. Beneficiaries would be able to enroll in the program at any time, with coverage beginning 6 months after enrollment. Also, the Part B premium surcharge for late enrollment would be revised based on the actuarially determined cost to Medicare of late enrollment. This provision will provide substantial relief to thousands of beneficiaries.

5 - Program Improvements

Respite Benefit - The President's Budget creates a respite benefit, beginning in FY 1998. This much-needed benefit will provide up to 32 hours of care each year for beneficiaries suffering from Alzheimer's and other irreversible dementia. Respite care may be provided at home or at a day-care facility, and will serve to ease the emotional "burnout" that is commonly experienced by primary caretakers, especially when they are family members. In the spirit of the Administration's efforts to improve the quality of family life, this benefit is an important step toward a community- and family-centered approach to health care.

6 - Integrated Quality Management

The President's budget would provide authority for HCFA to develop an integrated quality management system that would unify HCFA's quality assurance activities. Our current quality assurance activities are focused on minimum standards rather than the goal of achieving the best practicable health outcomes for beneficiaries. This new authority would allow us to assess the overall quality of care beneficiaries are receiving, and to require that care be effectively coordinated among different settings, rather than site by site as in our current system. As we move to require managed care plans to assess the overall quality of care they are providing to beneficiaries, we should be able to make the same determinations for beneficiaries who remain in fee-for-service Medicare.

CONCLUSION

We believe that the Administration's proposals outlined above are the best way to work toward our shared goals of providing access to quality health care for all Americans. For Medicaid, the President's 1998 Budget would continue the safety net protection for our most vulnerable citizens, achieving savings through greater flexibility for States to run more efficient Medicaid programs. We have looked beyond the immediate concerns of budget reductions and sought to keep our sights on the long-term goal, which is safeguarding the vitality of the Medicare

program. As our Nation evolves into a society with greater numbers of the elderly and infirm, we must preserve Medicare as a strong and vital program. The President's budget modernizes Medicare, extends the solvency of the Hospital Insurance Trust Fund by ten years, reduces the rate of growth in Medicare spending, and contributes to a balanced budget in 2002. It is essential that we protect Medicare, and our payment reforms and strategies will ensure that Medicare continues to be a sound investment in our Nation's health security for years to come.